9.2 Forms

The forms on the following pages may be photocopied for your use.

ADJUSTMENT/VOID Request Form

Please complete this form and attach appropriate documentation. If filing for an adjustment attach a corrected claim form.

Mail to: **Mississippi Medicaid Program**
P.O. Box 23077
Jackson, Mississippi 39225

1 Provider Information	2 Beneficiary Information
1a Provider Number	***2a Name***
1b NPI	
1c Provider Name	***2b Recipient ID Number***
	2c Date(s) of Service
1d Provider Address	***2d Transaction Control Number (TCN)***
	2e Line Numbers
	2f RA Date

3 Adjustment or Void *(Please check one of the following options)*

- ☐ 3a Adjustment
- ☐ 3b Void

4 Overpayment *(Please check one of the following, 4a is preferred option)*

- ☐ 4a Please deduct the overpayment from the future claims payments.
- ☐ 4b I have attached my personal check in the amount of the overpayment.
- ☐ 4c I have returned the State Warrant.

5 Description of Request *(Please check one of the following if applicable, if not please explain in the space below)*

- ☐ 5a Third Party Liability Recovery (Attach EOB)
- ☐ 5b Provider Corrections
- ☐ 5c Fiscal Agent Error
- ☐ 5d Claim Paid for Wrong Recipient
- ☐ 5e Claim Paid to Wrong Provider
- ☐ 5f LTC Medicaid Income Change
- ☐ 5g TPL Provider Audit Findings (Attach EOB as necessary)

Other Explanation:

6 Signature Block

6a Signature of Sender	***6b Mailing Date***

Mississippi Medicaid Use Only

Reason Code	***Initials***	***Date Stamp***
FCN	***Date***	
Claim Type / ***TXN Code***	***COS***	

CLAIMS INQUIRY Form

Please complete this form and attach appropriate documentation.

Mail to: **Mississippi Medicaid Program**
P.O. Box 23078
Jackson, Mississippi 39225

1 Provider Information

1a Billing Provider Number and/or Servicing Provider Number

1b NPI

1c Provider Name and Address

1d Point of Contact	***1e Provider Telephone***

2 Beneficiary Information

2a Name	***2b Recipient ID Number***
2c Date(s) of Service	***2d Transaction Control Number (TCN)***

3 Nature of Inquiry *(Please check one of the following if applicable, if not please explain in the space below)*

☐ 3a Claim Status ☐ 3b Explanation of denied Claim

Other Inquiry:

4 Signature Block

4a Signature	***4b Date***

Mississippi Medicaid Use Only

Reviewed by	***Date Stamp***
Action Taken	

DIRECT DEPOSIT AUTHORIZATION /AGREEMENT Form

Make one copy of this form for your records and mail original form with a copy of a voided check for the account to**:**

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

☐ New Application ☐ Change Bank Account Information

NOTE: Because of the Federal Cash Management Act, it is necessary for the Division of Medicaid to mandate the Direct Deposit of Medicaid payments to all Medicaid providers. With the weekly average Medicaid provider payments exceeding $20 million, without Direct Deposit the interest to the Federal government would have to be paid from all State funds that would other wise be used to match federal funds to make provider payments. Given Mississippi's favorable federal match rate, this would have the potential of reducing total program dollars by more than $10 million per year. This process has been underway since October 26, 1992 and has proven to be beneficial to both the State of Mississippi and the Medicaid providers. Please complete this form in order for us to complete your enrollment process and begin depositing your funds electronically.

Alert: If you choose not to complete this agreement you will not be assigned a Mississippi Medicaid Provider Number.

Provider Name	***Provider Contact***
Provider Number	***Provider Telephone Number***
NPI	

Provider's Address (City, State and Zip Code)

Bank Name

Bank Address (City, State and Zip Code)

Bank Account Number

Bank Transit/Routing Number

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents; or concealment of a material fact, may be prosecuted under applicable federal or state laws. I further authorize the Mississippi Medicaid agency to present credit entries (deposits) into the bank account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments for Medicaid services that the payee has rendered.

I further understand that in the event my bank account information were to change, I must notify the Mississippi Medicaid agency in order to change my bank account information immediately. I will not hold the Mississippi Medicaid agency liable for presentation of any and all credit entries (deposits) into the bank account referenced above and the depository named above if I fail to notify the Division of Medicaid or the fiscal agent of my change in bank account information.

Provider Signature	***Date***

CHANGE OF NAME Form

Please complete form.

Mail to: **Mississippi Medicaid Program**
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Required: Updated verification of the Tax ID and a copy of the new W-9 must be attached.

Provider Information

Medicaid Provider Number	***Name as Currently Shown on Remittance Advice***
NPI	
Name Change To (Please enter name as shown on W-9)	

Payee Bank Account Change

Prior Payment Bank
Prior Bank Routing Number
Prior Bank Account Number

Authorization for Change

Change Authorized By (Please Print Name)	
Signature	
Title	***Date***

CLAIM FORM REORDER REQUEST Form

Please complete form.

Mail to: **Mississippi Medicaid Program**
Attention Claim Form Reorder Request
P.O. Box 23076
Jackson, Mississippi 39225

Provider Information

Medicaid Provider Number	***Provider Name***
NPI	
Provider Address/Ship To (Street, City, State and Zip)	

Order Information

Order only a 2-3 month supply, allowing 2-3 weeks for delivery. A change of address may require 3-5 weeks for delivery. Be sure to notify the Provider Relations unit at ACS of any address change to avoid unnecessary delay.

Form Number	Title	25	50	100	300	Other	Quantity Shipped
DOM 210	Eyeglass/Hearing Aid Authorization Form						
DOM 260	Certification for Nursing Facilities						
DOM 260 DC	Certification for Disabled Child						
DOM 260HCBS	Certification for HCBS						
DOM 260 MR	Certification for ICF/MR						
DOM 301 HCBS	HM Comm-Based SVS/PH						
DOM 340	Pharmacy Authorization Request – Clorazil						
DOM 350	Pharmacy Authorization Request – Sandimmune						
DOM 413	Level II PASRR Billing Roster						
HCBS 105	Admit/Discharge HCBS for LTC						
MA 1001	Sterilization Consent Form						
MA 1002	Hysterectomy Acknowledgement Statement						
MA 1034	Medical Necessity for Abortion Form						
MA 1097	Dental Services for Orthodontics Authorization Request						
MA 1098	Dental Services Authorization Request						
MA 1103	DME Authorization						
MA 1148	Plan of Care Authorization Request						
MA-1104	DME/Home Health Authorization						
MA-1148A	Addendum to Plan of Care						
MS/ADJ	Adjustment Void Form						
MA 1165	Hospice Membership Form						
MS/INQ	Claim Inquiry Form						
MS/XOVE	Medicare/Medicaid Crossover Form – Part A						
MS/XOVE	Medicare/Medicaid Crossover Form Part – B						
MS PHAR	Pharmacy Claim Form						

Provider or Authorized Signature	***Date***

CHANGE OF ADDRESS FORM

Mail the completed form to: **Mississippi Medicaid Provider Enrollment**
P.O. Box 23078
Or Jackson, Mississippi 39225

Fax to: (601) 206-3015

Provider Information

Provider Name:

10-Digit National Provider Identifier (NPI):

8- Digit MS Medicaid Provider Number (Optional): Primary Taxonomy Code:

Change of Address Information

Please check the appropriate box below for the address type you wish to change.

☐ Servicing Address		Street Address City County State Zip Code
☐ Billing Address		Street Address City County State Zip Code
☐ Mail Other Address		Street Address City County State Zip Code
☐ Remittance Advice Address		Street Address City County State Zip Code
☐ 1099 Mailing Address	*W-9 Required	Street Address City County State Zip Code

**Please note that providers who wish to change the 1099 Mailing Address MUST submit a copy of the W-9 Form along with this form.*

☐ **All Addresses**	*W-9 Required	Street Address City County State Zip Code

Authorization for Change

I declare under penalty of perjury under the laws of the State of Mississippi that the information in this document and any attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the aforesaid Provider. I understand that Mississippi Medicaid Provider Enrollment will use the information in this document and its attachments to change my provider file.

Provider/ Authorized Representative (Please Print Name)

Signature **Date**

Trading Partner Service Agreement

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

The following constitutes a Trading Partner Service Agreement ("Agreement") between the Mississippi Division of Medicaid ("DOM"), its designated Fiscal Agent and the Billing Agency or Clearinghouse listed in Section II ("Trading Partner").

Section I—Terms of Agreement

The Trading Partner agrees to abide by the requirements for Administrative Simplification as defined in the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) based on the compliance date of the final rules or a date mutually agreed upon between the Trading Partner and the DOM or its designated Fiscal Agent.

The Trading Partner agrees to report to the DOM or its designated Fiscal Agent all billing information as directed by the Provider and agrees not to modify submitted information in any way unless directed to do so by the Provider.

The Trading Partner agrees to immediately report to the DOM or its designated Fiscal Agent when a DOM contracted Provider terminates services with the Trading Partner and to report all unsent transactions back to the Provider with the status of the individual transactions.

The Trading Partner agrees to send and receive data in a manner that protects the integrity and confidentiality of the transmitted information according to the relevant provisions of State and Federal laws and regulations.

The Trading Partner agrees to limit access to data to only those employees, agents, subcontractors and officials who need it to perform their duties in connection with this Agreement.

The Trading Partner agrees to not disclose any DOM beneficiary information without the prior consent of the DOM and the Provider and to remove beneficiary identifiers when appropriate and in compliance with State and Federal laws and regulations, such as in statistical reporting and in medical research studies.

The Trading Partner agrees to advise all personnel who will have access to the data of the confidential nature of the information, the safeguards required and the criminal sanctions for noncompliance contained in Federal and State Statutes.

The Trading Partner agrees to abide by the requirements for EDI submissions and submitters as published in the appropriate DOM Electronic Transactions Submission Manual.

The Trading Partner agrees to designate a person with whom the DOM or its designated Fiscal Agent can coordinate any activities that the DOM determines to be reasonable, necessary and proper for the effective performance of this Agreement.

If any information supplied in this Agreement changes at any time, the Trading Partner agrees to notify the DOM or its designated Fiscal Agent immediately in writing. Failure to do so may invalidate this Agreement.

In the event that State or Federal laws or regulations should change, alter or modify the present services, the terms, conditions and/or provisions of this Agreement shall be changed accordingly.

The Trading Partner agrees that the EDI Submitter ID is confidential and is not transferable or assignable.

This Agreement is not transferable or assignable and may be terminated by either DOM or the Trading Partner at any time upon giving to the other party thirty (30) days written notice of such termination.

Trading Partner agrees to indemnify and defend the DOM, its designated Fiscal Agent, agents, officers, and employees from and against any and all liability to third parties, including defense costs and reasonable legal fees, incurred in connection with claims for damages of any nature whatsoever, and arising from Trading Partner's wrongful performance or failure to perform its obligations hereunder.

This Agreement shall automatically terminate without notice to the Trading Partner in the event of liquidation or dissolution, adjudication as a bankrupt entity, the execution of an assignment for the benefit of creditors, the appointment of a receiver or a material portion of Trading Partner's assets and the Trading Partner will notify the DOM within five (5) days of such event.

Section II—Trading Partner Information
Please print or type. Complete all areas of the Agreement, unless otherwise indicated.

Billing Agency/Clearinghouse Name	***DOM's EDI Submitter Number (If Assigned)***
Contact Telephone Number	***Address***
Contact Facsimile Number	
Contact Name	
Authorized Agent's Name	***Contact E-Mail Address***
Authorized Agent's Title	***Authorized Agent's Signature***

I certify that all statements made herein are true and complete to the best of my knowledge.

Provider or Authorized Agent's Signature	***Date***

Mississippi Medicaid Program Use Only (Do not write in this section)

	Approved/Disapproved By
☐ Approved ☐ Disapproved	
EDI Submitter ID	***Password***
EDI Specialist	***Date Activated***
For Internal Use	

TPL EDIT OVERRIDE ATTACHMENT:
NO RESPONSE

This is to certify that a claim has been filed with the third party source named below with follow-up as required and that no response has been received in at least 60 days.

Name of Medicaid beneficiary: _____

Medicaid ID number: _____

TPL source name: _____

Address: _____

_____

Telephone number: _____

Policy number: _____

Date of original billing: _____

Date of follow-up: _____

I understand that the Division of Medicaid will research this matter. If no claim has been received by the TPL source, the Medicaid payment will be voided via the payment register with a message to bill the third party.

_____ _____

Signature of provider or billing clerk Date

_____

Phone Number

Medicaid Title XIX Pharmacy Invoice

☐ 72 Hour Emergency Supply
☐ Dispute Reimbursement
☐ Retro Eligibility
☐ TPN/ Special Pricing Claim

State of Mississippi
Division of Medicaid
P.O. Box 23076
Jackson, MS 39225

PROVIDER INFORMATION			
[1]Provider Name	[2]NPI _ _ _ _ _ _ _ _ _ _	[3]Medicaid Number _ _ _ _ _ _ _ _	[4]Phone # Fax #
[5]Street Address	[6]City	[7]State	[8]Zip Code

BENEFICIARY INFORMATION	[9]Medicaid ID _ _ _ _ _ _ _ _ _ Medicare # _ _ _ _ _ _ _	
[10]Last Name	[11]First Initial	[12]DOB _ _/_ _/_ _ _ _

1	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
2	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
3	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
4	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
5	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under that state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency request. I further agree to accept as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized co-payment.

26. Pharmacist's Signature: _____ 27. Date: _____

28. Pharmacist's Name Printed: _____

Medicare Part **A**

MISSISSIPPI CROSSOVER CLAIM FORM

State of Mississippi Medicaid Program

For Medicare Part C ONLY

1. Type of Bill

2. Provider Name and Address	3. Medicaid Provider Number	4. Recipient Name & Address	5. Recipient Medicaid ID
	3a. NPI Number		

6. Patient Acct/Medical Record No.	Admission 7. Date	8. Hour	9. Type	10. Dates of Service From	Thru	11. Cov. Days

12. Diagnosis Primary	Secondary
3rd	4th

13. Total Medicare Billed Charges	14. Total Medicare Allowed Amount	15. Total Medicare Paid Amount

16. Total Medicare Deductible Amount	17. Total Medicare Co-insurance Amount	18. Total Medicare Blood Deductible Amount	19. Medicare Paid Date	20. Total Third Party Payment Amount

	21. Revenue Code	Procedure Code	22. Units	23. Medicare Billed Amount	24. Medicare Non-Covered Amount	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

25. Provider Signature	26. Billing Date

Revised 8/25/08

Medicare Part **B**

MISSISSIPPI CROSSOVER CLAIM FORM

State of Mississippi Medicaid Program

For Medicare Part C ONLY

1. Provider Name and Address	2a. Medicaid Provider Number	3. Recipient Name & Address	4. Recipient Medicaid ID
	2b. NPI Number		

5. Patient Account / Medical Record Number

6. Diagnosis	
Primary	Secondary
3rd	4th

	7. Service Dates From	Thru	8. Procedure Code	9. Modifier	10. Service Units	11. Medicare Billed Charges	12. Medicare Allowed Amount
	13. Medicare Non-covered Amt.	14. Medicare Blood Deductible	15. Medicare Paid Amount	16. Medicare Deductible	17. Medicare Co-insurance	18. Medicare Paid Date	19. Third Party Amount
1						.	.
2						.	.
3						.	.
4						.	.
5						.	.
6						.	.

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

20. Provider Signature	21. Billing Date

Revised 08/25/08